SEND OR FAX FORM TO:
Ms. Samantha Lyons
Drug Court Coordinator
50 Maryland Avenue
Rockville, MD 20850
Fax: 240-777- 9117
Phone: 240-777-9141

DRUG COURT REFERRAL FORM

Date: _____

Defendant's Name: _____

Case Number (s): _____

Defendant's most CURRENT address and phone number:

_____

_____

Is the Defendant currently incarcerated?

Yes ☐ No ☐ If yes, which facility? ☐ MCDC ☐ MCCF ☐ Other:_____

REFERRAL MADE BY (please place a check in the appropriate box **AND** *also include the names and phone numbers of the other parties so that we may advise them of this referral):*

☐ Judge: _____ (Name) _____ (Phone)

☐ Defense Counsel: _____ (Name) _____ (Phone)

☐ State's Attorney: _____ (Name) _____ (Phone)

☐ Parole and Probation Or Other _____ (Name) _____ (Phone)

Brief summary of why you believe that the defendant is a candidate for Drug Court:

_____

_____

_____

_____

_____

The eligibility criteria for acceptance into Drug Court are that the Defendant must be a resident of Montgomery County, addicted to / dependent on alcohol and/or other drugs, amendable to, and mentally / physically capable of, participating in an intensive outpatient program, and must be non-violent. Considering the eligibility criteria, are you aware of any circumstances that may make the Defendant **ineligible** for Drug Court? **Yes** ☐ **No** ☐

If yes, please briefly explain: _____

_____

_____

_____

May we schedule and send the Defendant for his/her eligibility assessment and treatment evaluation through the Outpatient Addiction Services (OAS) Unit at the Department of Health and Human Services? **Yes** ☐ **No** ☐